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In the Supreme Court of the United States

OCTOBER TERM, 1992

GOOD SAMARITAN HOSPITAL, ET AL., PETITIONERS

v.

LOUIS W. SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE RESPONDENT

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

EDWIN S. KNEEDLER
Assistant to the Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys

Department of Justice
Washington, D.C. 20530
(202) 514-2217

SUSAN K. ZAGAME
Acting General Counsel

DARREL J. GRINSTEAD
Associate General Counsel

HENRY R. GOLDBERG
Deputy Associate General Counsel

GERARD KEATING
Attorney
Department of Health & Human Services
Washington, D.C. 20201

QUESTION PRESENTED

Whether a health care provider may invoke 42 U.S.C. 1395x(v)(1)(A)(ii), which authorizes regulations providing for the making of "suitable retroactive corrective adjustments" to Medicare reimbursements, to obtain reimbursement in excess of valid regulatory cost limits that are specifically authorized by Section 1395x(v)(1)(A).

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-17a) is reported at 952 F.2d 1017. The decision of the district court (Pet. App. 19a-36a) is not officially reported.

JURISDICTION

The judgment of the court of appeals was entered on December 30, 1991. A petition for rehearing was denied on February 7, 1992. Pet. App. 18a. On April 28, 1992, Justice Blackmun extended the time for filing a petition for a writ of certiorari to and including July 6, 1992. The petition was filed on June 26, 1992, and was granted on October 13, 1992. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1. The Medicare program, enacted in 1965 as Title XVIII of the Social Security Act,[1] provides for payment of certain medical expenses on behalf of eligible aged and disabled persons. Under Part A of the Medicare program, hospitals, skilled nursing facilities and home health agencies are reimbursed for primary care that they provide to Medicare beneficiaries. See 42 U.S.C. 1395c to 1395i-4 (1988 & Supp. II 1990). The Act directs the Secretary of Health and Human Services to "periodically determine the amount which should be paid under [Part A] to each provider" for services furnished to Medicare beneficiaries, and to pay the amounts so determined to the provider at least monthly, with adjustments necessary to account for past overpayments and underpayments. 42 U.S.C. 1395g. Such interim payments are made on the basis of the provider's estimated costs. See 42 C.F.R. 413.64(e) and (f). At the end of the cost year, the provider submits a cost report, which furnishes the basis for the Secretary's fiscal intermediary to determine the provider's actual reimbursable costs for that year. See 42 C.F.R. 405.1803, 413.20(b), 413.24(f); see also *id.* §§ 413.9(b), 413.64(f).[2]

For the years at issue, a Part A provider was reimbursed for the "reasonable cost" of the services it furnished or its "customary charges" for those services, whichever was less. 42 U.S.C. 1395f(b)(1) (1982).[3]

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[1] Pub. L. No. 89-97, 79 Stat. 291, codified at 42 U.S.C. 1395 *et seq.*

[2] The Part A program is administered on the Secretary's behalf by fiscal intermediaries (typically private insurance companies), whose decisions on cost reports may be appealed to the Provider Reimbursement Review Board. See 42 U.S.C. 1395*oo*; *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399 (1988).

[3] Beginning on October 1, 1983, most hospital inpatient services under Part A have been reimbursed in accordance with fixed rates

Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services," and it directs the Secretary of Health and Human Services to promulgate regulations establishing the method or methods for determining reasonable cost. 42 U.S.C. 1395x(v)(1)(A). The same section also requires the regulations to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) [hereinafter "clause (ii)"]. The Secretary has issued comprehensive regulations establishing principles of reasonable cost reimbursement. See 42 C.F.R. Pt. 413. As required by clause (ii), those regulations provide for retroactive corrective adjustments after the provider has submitted its final cost report for the fiscal year. "The retroactive adjustment will represent the difference between the amount received by the provider [in interim payments] during the year for covered services * * * and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of

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prescribed under the Prospective Payment System (PPS). See 42 U.S.C. 1395ww(d); 42 C.F.R. Pt. 412. The PPS system is not at issue here. PPS does not apply, however, to skilled nursing facilities or home health agencies. We have been informed by the Health Care Financing Administration (HCFA) in the Department of Health and Human Services that there are 6,211 skilled nursing facilities and 6,009 home health care agencies currently participating in the Medicare program. Those providers receive approximately $7.65 billion annually in Medicare payments, and HCFA estimates that approximately $400 million in claims are disallowed each year as a result of applicable cost limits. In addition, 2,832 hospitals are excluded from PPS and are instead subject to rate-of-increase limits, similar to the Secretary's cost limits, under 42 U.S.C. 1395ww(b) (1988 & Supp. II 1990). See 42 C.F.R. 412.22-412.23 (1991).

services furnished to beneficiaries during the year." 42 C.F.R. 413.9(b); see also *id.* § 413.64(f).

At the inception of the Medicare program, essentially all of a provider's "actual costs" were "allowable," however widely they might have varied among providers or even among a single provider's patients, so long as the costs were not "substantially out of line" with those of similar institutions. See, *e.g.*, 20 C.F.R. 405.451(c) (1967).[4] Such "allowable" costs were apportioned between a provider's Medicare and non-Medicare patients in order to determine the "reasonable cost" of services reimbursable under the Medicare program. See *id.* §§ 405.403, 405.452. Congress soon became concerned, however, that in practice the "reasonable cost" standard allowed providers to recover whatever costs they incurred, no matter how inefficiently. See H.R. Rep. No. 231, 92d Cong., 1st Sess. 82-85 (1971); S. Rep. No. 1230, 92d Cong., 2d Sess. 188-189 (1972). Congress responded to that problem in 1972 by revising 42 U.S.C. 1395x(v)(1)(A) to tighten the statutory definition of "reasonable cost" and to authorize the Secretary to promulgate regulations establishing limits ("based on estimates of the costs necessary in the efficient delivery of needed health services") on the costs that would be "recognized as reasonable" for purposes of Medicare reimbursement. Pub. L. No. 92-603, § 223, 86 Stat. 1393-1394.

In 1974 the Secretary promulgated the first regulations establishing cost limits for certain items and services, together with an initial schedule of per diem limits ap-

[4] The regulations concerning determination of costs reimbursable under Medicare were originally codified at 20 C.F.R. 405.401-405.454 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405, see 42 Fed. Reg. 52,826 (effective October 1, 1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (effective October 1, 1986). We give parallel citations only when it seems useful to do so. The key provisions cited herein have remained substantially unchanged since their original promulgation.

plicable to inpatient "general routine service costs." 39 Fed. Reg. 20,164, 20,168-20,170 (1974); see 20 C.F.R. 405.460 (1975), redesignated as 42 C.F.R. 413.30. The cost limits in force have been updated annually since then. See, *e.g.*, 57 Fed. Reg. 29,410 (1992) (home health agencies); 57 Fed. Reg. 46,177 (1992) (skilled nursing facilities). The limits are based on provider classifications and other factors the Secretary finds "appropriate and practical," including type of service furnished, geographical area, institutional size, nature and mix of services furnished by the provider, and patient mix. See 42 C.F.R. 413.30(b).

The regulations establish a general rule that reimbursable costs may not exceed the applicable cost limits. 42 C.F.R. 413.30(a)(2). The regulations do, however, specify circumstances in which the limits may be exceeded. For example, an exemption from the cost limits may be granted to new providers, sole community hospitals, and small rural hospitals. 42 C.F.R. 413.30(e). In addition, an exception may be granted in particular situations involving, *inter alia*, atypical services, extraordinary circumstances beyond the provider's control, or essential community hospital services. 42 C.F.R. 413.30(f).[5]

2. During the cost years at issue in this case, the Secretary classified providers according to two criteria for cost limit purposes: (a) an area wage index, and (b) location within or without a Standard Metropolitan Statistical Area (SMSA).

[5] Exceptions operate differently from exemptions. Exemptions attach to the operations of any provider that falls into an exempt category. Exceptions involve careful evaluation of particular circumstances, and lead to an adjustment "only to the extent the [excess] costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified" by program administrators. 42 C.F.R. 413.30(f).

a. The Secretary adopted the wage index system in 1979 as a way of adjusting for variations in wage levels among geographical areas. 44 Fed. Reg. 11,612, 11,613 (1979).[6] Initially, the Secretary relied for this index on data obtained from the Bureau of Labor Statistics (BLS). *Ibid.* The BLS data were criticized because, among other things, they failed to account for local variations in the proportion of part-time to full-time workers. The Secretary concluded, however, that the BLS statistics were the "most reliable data available" at the time. See, *e.g.*, 45 Fed. Reg. 41,868, 41,871 (1980); 49 Fed. Reg. 234, 257 (1984).[7]

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[6] Prior to adoption of a wage index, the Secretary had used per capita income in the area to adjust for variations in wage levels among providers. Most public comments on the proposed wage index agreed that such an index was an improvement over the use of per capita incomes. 44 Fed. Reg. 31,806, 31,807 (1979).

[7] Petitioners complain (Pet. Br. 5 & n.4) that distortions in the BLS data were "known by the Secretary from the earliest use of the wage index." That assertion is irrelevant here, given that petitioners were unsuccessful below in their challenge to the reasonableness of the Secretary's cost limits, including the wage index (see page 10, *infra*), and have not renewed that challenge in this Court. In any event, the Secretary has maintained only that the BLS data were adequate, not that they were perfect. The July 1981 Memorandum prepared by the Health Care Financing Administration which petitioners cite (Pet. Br. 5 n.3) noted that although the "BLS data cause unavoidable distortions affecting the accuracy of the index for some locales," they represent the "best source currently available" because "[t]here is no other data source of national scope which will eliminate the[se] index distortions * * *." Pltf's Mot. for Summ. Jdgmt., Exh. D, at 1, 5. Moreover, the Secretary "proposed in 1981 to develop an appropriate database [to take account of part-time workers] by modifying the Medicare cost report, but the proposal was delayed in part because of opposition from the hospital industry." *Mt. Diablo Hospital* v. *Sullivan*, 963 F.2d 1175, 1180 (9th Cir. 1992), petition for cert. pending, No. 92-720. See also 49 Fed. Reg. 27,438, 27,439 (1984) (in 1983, HCFA established a joint working group of participants from various state associations to evaluate alternatives to the BLS data).

In 1984, Congress directed the Secretary to conduct a wage index study to adjust for variations in the numbers of part-time employees. Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2316(a), 98 Stat. 1081. Based on data obtained through that study, the Secretary revised the wage index in 1986 to account for part-time employees. 51 Fed. Reg. 16,772 (1986). Congress subsequently directed that the revised index be applied to patient discharges occurring on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156.

b. As noted above, during the years at issue providers were also classified demographically. In 1974, the Secretary decided to use a provider's location within a Standard Metropolitan Statistical Area "as a proxy for an urban location." Locations not within an SMSA[8] were considered "nonurban" or rural. 39 Fed. Reg. 20,168 (1974). Because it is generally more expensive to operate a hospital in an urban area than in a rural one, 44 Fed. Reg. 11,613 (1979), HCFA set a higher cost limit for providers within an SMSA than for providers outside an SMSA.

3. Petitioners are six rural Nebraska hospitals whose costs exceeded the applicable cost limits for some of the years between 1980 and 1984. On review of their cost reports for those years, petitioners challenged the validity of the applicable cost limits. They also asked the Secretary's Provider Reimbursement Review Board (PRRB) for a "suitable retroactive corrective adjustment," citing clause (ii) of 42 U.S.C. 1395x(v)(1)(A) as authority for an individualized departure from the cost limits, even though they did not qualify for an exemption from or

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[8] In 1983, the Office of Management and Budget changed this terminology to Metropolitan Statistical Area (MSA). For convenience, we will continue to use the term SMSA here.

exception to those limits under the regulations. In particular, petitioners claimed that the cost limits did not properly account for the high proportion of part-time employees in their work force, and did not permit rural hospitals to show that they incurred costs similar to those of urban hospitals. The PRRB, which is bound by the Secretary's regulations, concluded that it lacked authority over petitioners' legal challenges, thus allowing petitioners to seek immediate judicial review. Pet. App. 37a-54a; 42 U.S.C. 1395*oo*(f)(1).

Petitioners then filed this suit in the United States District Court for the District of Nebraska. They contended (1) that the wage index was arbitrary and capricious, because it was "calculated without regard to the effect of the use of part-time or full-time employee data"; (2) that classification of hospitals as rural or urban "without possibility of an exception" had "no rational basis"; and (3) that they were in any event entitled by clause (ii) of 42 U.S.C. 1395x(v)(1)(A) to relief in the form of "suitable retroactive corrective adjustments to the costs limits." J.A. 13-15. Petitioners requested an order declaring the applicable cost limit schedules "illegal on their face" or, in the alternative, "an order requiring the Secretary to reimburse [petitioners] for their reasonable costs for the years under appeal without regard to the cost limits." J.A. 18-19.[9]

The district court granted summary judgment for petitioners. Pet. App. 19a-36a. The court did not address petitioners' facial challenge to the wage index and rural/urban classifications used in establishing the cost limits. Rather, it agreed with petitioners that "the Secretary must allow [them] an opportunity, under clause (ii), to demonstrate that they are entitled to reimbursement of reasonable costs beyond the amount already determined [to be] reasonable under the cost limits schedule." *Id.* at 26a. Adhering to the Eighth Circuit's decision in *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (1987), the district court held that "[t]he Secretary has a statutory duty under clause (ii) to ensure that the necessary corrective adjustments are made whenever the methods of cost calculation fail to reimburse a provider for its reasonable costs." Pet. App. 29a. It accordingly rejected the Secretary's contention that clause (ii) "only authorizes a year-end 'book balancing' adjustment" to ensure that the provider "receives what is due under the cost limits as applied." Pet. App. 27a-28a, 31a-33a. The court remanded the case to the Secretary for "consideration of [petitioners'] reasonable expenses in excess of the cost limit rules in effect for the years under appeal." *Id.* at 32a.

4. The court of appeals reversed. Pet. App. 1a-17a. The court agreed with the Secretary that its prior interpretation of clause (ii) in *St. Paul-Ramsey* was effectively overruled by this Court's decision in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988). Pet. App. 11a. Under *Georgetown*, the panel explained, "clause (ii) does not permit changes in the methods used to reimburse costs, but only corrective adjustments to the aggregate amounts" disbursed to providers. *Id.* at 12a. Accordingly, clause (ii) "merely allows a year-end book balancing of the monthly installments with the aggregate amount due for the year." *Ibid.* On this basis, the court rejected petitioners' claims for additional reimbursement under clause (ii), holding that the relief petitioners sought—to have "the methodology changed to correct

[9] A provider's reimbursable costs for its cost period ending after September 30, 1982 (at issue for each petitioner in this case) determines the provider's "base year" costs under the Prospective Payment System. See note 3, *supra*. Base year costs in turn affect the provider's reimbursable costs for each of the first four PPS years. If petitioners are successful in obtaining additional reimbursement for 1982 in this case, they are entitled to an upward adjustment in their "hospital-specific" reimbursement rate under PPS for the four subsequent years. J.A. 16-19.

what they believe are inequalities in the system"—would "amount to a retroactive change in the *methods* used to compute costs that, after *Georgetown*, is invalid." *Id.* at 13a. Such a methodological change would constitute a "second bite at the apple" on claims for reimbursable costs, a result that clause (ii) "does not allow." *Id.* at 13a-14a (citing *Hennepin County* v. *Sullivan*, 883 F.2d 85, 92 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990), and *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990)).

The court of appeals also upheld the validity of the Secretary's cost limit regulations, finding "nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a. The court explained that "[b]oth the wage index and the rural/urban distinction were based on objective data and regulations," and it rejected petitioners' argument that the regulations' failure to account for part-time workers and the use of SMSA criteria to designate "urban" hospitals rendered the limits invalid. *Ibid.*

SUMMARY OF ARGUMENT

In the courts below, petitioners challenged the validity of the cost limits prescribed by the Secretary for the years in question. The court of appeals rejected that challenge, and petitioners do not renew it here. Instead, petitioners seek to use clause (ii) of 42 U.S.C. 1395x (v)(1)(A) to achieve the same result. Petitioners' expansive interpretation of clause (ii) is at odds, however, with the language of the clause, the statutory language as a whole, the history and contemporaneous interpretation of the relevant provisions, and this Court's decision in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988). Petitioners' approach would undermine the efficacy of the cost limits specifically authorized by Congress, and convert the orderly reimbursement scheme that now exists into an endless series of *ad hoc* determinations in derogation of otherwise valid regulatory standards.

The plain language of clause (ii) supports the Secretary's interpretation of its function. The clause's "retrospective" and "corrective" thrust are consistent with the Secretary's view that it contemplates adjustments of a "book-balancing" nature, rather than the type of broad exceptions (with prospective as well as retrospective practical effect) sought by petitioners. Similarly, the Secretary's interpretation—unlike that advanced by petitioners—respects the clause's focus on the aggregate reimbursement produced by the applicable cost determination methods, the relationship of the clause (ii) adjustment to the interim payment system established under 42 U.S.C. 1395g, and the statutory command that validly promulgated cost limits be "recognized as reasonable" for Medicare purposes. At the very least, the Secretary's implementation of clause (ii), through regulations that form an integral part of the complex regulatory scheme mandated by the statute to give content to the "reasonable cost" standard, represents a permissible construction of the statute and is entitled to judicial deference.

The meaning of clause (ii) that is evident from its language and the text of 42 U.S.C. 1395x(v)(1)(A) as a whole is confirmed by its history and contemporaneous interpretation. The legislative history of clause (ii) itself suggests no reason for departing from the interpretation required by its text. Moreover, the initial regulations implementing the Medicare reimbursement provisions, promulgated little more than a year after the statute's enactment, reflect in their language and structure precisely the "book-balancing" interpretation of clause (ii) that the Secretary relies on here. This interpretation was also brought to the attention of Congress within a year of the statute's enactment. From the outset, clause (ii) was interpreted as an important but

limited provision relating to year-end accounting under the reimbursement provisions; there was no suggestion of the different and far more expansive role urged by petitioners.

Congress toughened the governing principles of cost reimbursement in 1972, in part by authorizing the Secretary to promulgate "limits on the * * * incurred costs * * * to be recognized as reasonable" for Medicare purposes. Petitioners concede that they do not qualify for any exemption or exception from the cost limits thereafter promulgated by the Secretary. They contend, however, that clause (ii) confers on them a substantive right to individual, *ad hoc* adjudication of their claim that certain of their costs were "reasonable," and hence reimbursable without regard to the otherwise valid cost limit rules. In fact, petitioners are merely trying to use clause (ii) to fight again the battle that they lost when the court of appeals correctly refused to invalidate the cost limits applicable to petitioners for the years in issue.

Petitioners' reliance on clause (ii) in this case is foreclosed, however, by this Court's decision in *Bowen* v. *Georgetown University Hospital*, *supra*. In *Georgetown*, the Court rejected an interpretation of clause (ii) that would have authorized retroactive, substantive cost reimbursement regulations. The Court's discussion of clause (ii) makes clear that the clause plays only the more limited role assigned to it by the initial regulations—which the Court cited with approval—and advanced by the Secretary here. *Georgetown* specifically states that clause (ii) does not permit changes in the methods, including costs limits, used to compute "reasonable costs," and disapproves exactly the sort of wholesale retroactive revision of cost determination methods that would be the practical effect of accepting petitioners' position.

Finally, petitioners make much of the fact that the Secretary's position on the meaning of clause (ii) has varied at times between the inception of the program and the decision in *Georgetown*. The Secretary's varying position stemmed largely, however, from the disarray that prevailed among the lower courts on this issue for some time before *Georgetown*. Since *Georgetown*, and taking into account this Court's authoritative construction of the statute in that case, the Secretary has returned to his original construction. The fact that the Secretary once took a somewhat broader view does not affect the validity of his current position, or the deference due it from the courts.

ARGUMENT

A MEDICARE PROVIDER CANNOT CIRCUMVENT VALID COST LIMITS IN THE SECRETARY'S REIMBURSEMENT REGULATIONS BY INVOKING THE PROVISION IN CLAUSE (ii) OF 42 U.S.C. 1395x(v)(1)(A) FOR "SUITABLE RETROACTIVE CORRECTIVE ADJUSTMENTS"

In the courts below, petitioners challenged the cost limits prescribed by the Secretary for the years in question on the ground that the wage index and SMSA classifications on which the limits were based did not fully recognize the costs petitioners reasonably incurred. The court of appeals rejected that challenge, and petitioners do not renew it here. Accordingly, as the case comes to this Court, the cost limits must be regarded as entirely lawful in their application to petitioners for the years in question.

Petitioners now seek through clause (ii) of 42 U.S.C. 1395x(v)(1)(A) precisely the same result—avoidance of the cost limits—that outright invalidation of those limits would have accomplished. They contend that the requirement in clause (ii) that the Secretary's "reasonable cost" regulations provide for "suitable retroactive corrective adjustments" in certain circumstances entitles them to reimbursement in excess of the valid cost limits promulgated pursuant to the immediately preceding sentence of 42 U.S.C. 1395x(v)(1)(A). Petitioners' expan-

sive vision of clause (ii) is inconsistent with the carefully circumscribed language of clause (ii), the text of 42 U.S.C. 1395x(v)(1)(A) as a whole, the history and contemporaneous interpretation of those provisions, and this Court's decision in *Bowen* v. *Georgetown University Hospital*, *supra*. In addition, the approach petitioners urge would undermine the efficacy of the cost limits that Congress specifically authorized. The result would be to convert the existing system of orderly reimbursement within the regulatory framework implementing the statutory "reasonable cost" standard into an endless series of *ad hoc* determinations in derogation of otherwise valid regulatory standards.

A. The Text Of The Act Supports The Secretary's Implementation Of Clause (ii) Through Regulations That Provide Only For A Year-End, "Book-balancing" Adjustment Of A Provider's Total Reimbursement Within The Framework Of The Cost Limit Regulations

"The starting point in statutory interpretation," of course, "is 'the language [of the statute] itself.'" *Ardestani* v. *INS*, 112 S. Ct. 515, 519 (1991) (quoting *United States* v. *James*, 478 U.S. 597, 604 (1986)). If "Congress has directly spoken on the precise question at issue" and "the intent of Congress is clear, that is the end of the matter"; "the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-843 (1984). See also *Estate of Cowart* v. *Nicklos Drilling Co.*, 112 S. Ct. 2589, 2594 (1992). On the other hand, "[i]f * * * Congress has not directly addressed the precise question at issue," the question is "whether the agency's answer is based on a permissible construction of the statute," for "considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer." *Chevron*, 467 U.S. at 843-844.

Such deference is especially appropriate in this case, because the Social Security Act (of which the Medicare Act is a part) "is among the most intricate ever drafted by Congress," and Congress accordingly has "conferred on the Secretary exceptionally broad authority to prescribe standards" by regulation. *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981); see 42 U.S.C. 1302, 1395x(v)(1)(A), 1395hh. Finally, of course, "a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context." *King* v. *St. Vincent's Hospital*, 112 S. Ct. 570, 574 (1991) (citations omitted).

The foregoing principles support the validity of the Secretary's regulations implementing clause (ii). Under those regulations, the adjustments contemplated by clause (ii) are essentially of a "book-balancing" nature, reflecting the difference between the total of the interim payments received by the provider during the year, based on its estimated costs, and the actual costs the provider is found at the close of the year to have properly incurred under the Secretary's regulations. 42 C.F.R. 413.9(b), 413.64(f). Conversely, the text of the Act refutes petitioners' interpretation of clause (ii), under which a provider would be entitled to seek reimbursement in excess of the valid cost limits prescribed in the regulations simply by claiming that its higher costs satisfied some vague standard of "reasonableness."

Clause (ii) is contained in Subsection (1)(A) of Section 1861(v) of the Act, which sets forth the statutory definition of "reasonable costs." 42 U.S.C. 1395x(v). Subsection (1)(A) states in pertinent part:

> The reasonable cost of any services * * * shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included * * *. Such regulations * * * may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items

> or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health serviecs to individuals covered by the insurance programs established under [Medicare] * * *. Such regulations shall * * * (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

This language supports the limited role of clause (ii) reflected in the Secretary's regulations, and undermines petitioners' far more expansive and open-ended vision of the clause.

First, the entire thrust of clause (ii) is retrospective, indicating that it comes into play only at the end of an accounting period and therefore serves an accounting purpose. Thus, clause (ii) refers to "retroactive" adjustments, for a "fiscal period," where aggregate reimbursement "proves" to be either inadequate or excessive. The Secretary's year-end, book-balancing approach is consistent with that focus. By contrast, if Congress had intended clause (ii) to afford a provider a right to insist upon individualized *exceptions* to regulatory standards (including cost limits) on equitable grounds, as petitioners contend, there would have been no reason to give it only retrospective effect.

Second, clause (ii) refers to "corrective" adjustments. That reference strongly suggests that clause (ii) is modest in scope and contemplates only the elimination of inaccuracies in the application of reimbursement methods prescribed by regulation—*e.g.*, where year-end data concerning actual costs show that the estimates on which interim payments were based were erroneous—not the revisiting of substantive reimbursement policies. By contrast, petitioners' interpretation pays no heed to the term "corrective." Petitioners' approach would necessitate a fresh inquiry into substantive reimbursement issues at

the end of each year, and would require an adjustment even where the reimbursement methods prescribed by regulation had been properly applied on the basis of accurate data.

Third, clause (ii) focuses on whether the "aggregate" reimbursement produced by *all* "methods" employed in determining reasonable costs for the provider for the fiscal period was either inadequate or excessive. The quoted terms indicate that clause (ii) takes the various "methods" prescribed by the Secretary as a given, and is concerned only with the bottom-line issue addressed by the Secretary's book-balancing regulations. Petitioner's approach, by contrast, would disaggregate the inquiry and permit the provider to question and seek a departure from each and every "method" (validly prescribed by the Secretary) that was utilized in calculating the provider's reasonable costs. The Secretary's implementation of clause (ii) through the book-balancing regulations also comports with 42 U.S.C. 1395g, which provides for interim, pre-audit payments to providers based on estimated costs. That Section necessarily contemplates some mechanism under other provisions of the Act, to reconcile those interim payments with the provider's actual costs at the end of the year. Clause (ii) provides that mechanism. Petitioner's approach ignores this relationship between clause (ii) and 42 U.S.C. 1395g.

Fourth, clause (ii) requires a corrective adjustment only where the aggregate reimbursement proves to be either "inadequate" or "excessive." But inadequate or excessive compared to what? The answer must be: inadequate or excessive compared to the statutory standard of reasonableness in 42 U.S.C. 1395x(v)(1)(A) itself. The content of that standard is found in the various "methods" including cost limits) that are contained in the regulations prescribed by the Secretary for determining reasonable costs. Petitioners contend (Pet. Br. 13, 21-22) that clause (ii) requires reimbursement of *all* costs they may show to be "reasonable" under some un-

specified standard, regardless of the "methods" established by the Secretary's regulations. This contention ignores the third sentence of 42 U.S.C. 1395x(v)(1)(A), which not only authorizes the Secretary to establish cost limits, but also provides that they shall "be recognized as reasonable." It also ignores the fact that clause (ii) only requires the regulations to provide for those retroactive corrective adjustments that are "suitable." The Secretary may properly determine that it is not "suitable" to provide for adjustments to accommodate a provider's disagreement with validly promulgated cost limits.

Finally, clause (ii) does not authorize an *ad hoc* disregard of the Secretary's reimbursement regulations, as petitioners would have it, but rather prescribes one feature that those regulations must contain—a provision for "retroactive corrective adjustments." Those "retroactive adjustments" must be made against the standard of the cost limits themselves, since those limits are also contained in the regulations and represent, by definition, "reasonable costs."

At the very least, the Secretary's position that clause (ii) does not require the sort of adjustment petitioners seek is based on a permissible construction of clause (ii) and of 42 U.S.C. 1395x(v)(1)(A) as a whole. It therefore should, under *Chevron*, be sustained. Indeed, the fact that clause (ii) is to be implemented through regulations, as an integral part of the complex regulatory scheme giving content to the statutory "reasonable cost" standard, confirms that Congress has delegated that implementation to the Secretary in a manner that commands particular deference by the courts. See, *e.g.*, *Bowen* v. *Yuckert*, 482 U.S. 137, 145 (1987); *Batterton* v. *Francis*, 432 U.S. 416, 424-426 (1977).

B. The History Of Clause (ii) And The 1972 Amendments Authorizing Cost Limits Both Support The Secretary's Interpretation Of Clause (ii) In This Case

The meaning of clause (ii) evident from its language and the text of 42 U.S.C. 1395x(v)(1)(A) as a whole is confirmed by its history and contemporaneous interpretation. This case specifically involves the interaction of clause (ii) and the regulatory cost limits promulgated by the Secretary under explicit authority granted in the immediately preceding sentence of 42 U.S.C. 1395x(v)(1)(A). Clause (ii) has been part of the Medicare program since its inception in 1965, but the authorization for cost limits was added by 1972 amendments to the Medicare statute. Both the original enactment and subsequent amendments support the court of appeals' rejection of petitioner's reliance on clause (ii) to avoid the cost limits.

1. *Clause (ii) as Originally Enacted*

a. The Medicare program was established by the Social Security Amendments of 1965, Pub. L. No. 89-97, § 102, 79 Stat. 291, which added a new Title XVIII, comprising Sections 1801-1875, to the Social Security Act. Section 1814(b) of the new title, 79 Stat. 296 (codified at 42 U.S.C. 1395f(b)), provided that hospitals and other health care providers were to be reimbursed (subject to certain coinsurance and deductible amounts) for the "reasonable cost" of the services they provided. Section 1815, 79 Stat. 297 (codified at 42 U.S.C. 1395g), directed the Secretary to "periodically determine the amount which should be paid * * * to each provider of services with respect to the services furnished by it," and to pay "the amounts so determined" to the provider no less often than monthly. Section 1814(b) specified that the "reasonable cost"—*i.e.*, the amount to be paid to the provider—was to be "determined" under Section 1861(v), 79 Stat. 322-

323 (codified at 42 U.S.C. 1395x(v)). That section, in turn, provided for "regulations establishing the method or methods to be used, and the items to be included, in determining such costs." Those regulations could permissibly prescribe any of a variety of cost determination techniques,[10] but were required by clause (i) to take into account indirect as well as direct costs and by clause (ii) to "provide for the making of suitable retroactive corrective adjustments."[11] The legislative history of the latter clause furnishes no reason to depart from the interpretation required by its text, discussed at pages 15-18, *supra*. The Senate and House reports simply repeat the language of clause (ii), without further explanation. S. Rep. No. 404, 89th Cong., 1st Sess. Pt. I, at 186 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 168-169 (1965).

b. The interpretation of clause (ii) required by its text was reflected in the regulations implementing the cost provisions of Title XVIII that were issued in final form in November, 1966, little more than a year after enactment of the Medicare program. 31 Fed. Reg. 14,808. The regulations restated the "reasonable cost" principle, 20 C.F.R. 405.401(a) (1967), and implemented statements in the congressional committee reports that the Act contemplated reimbursement for a provider's "actual costs, however widely they may vary from one institution to another," subject to limitation only where a particular provider's costs were found to be "substantially out of line" with those of similar institutions. 20 C.F.R. 405.451(c) (1967); see S. Rep. No. 404, *supra*, at 35-36; H.R. Rep. No. 213, *supra*, at 31-32.

[10] "Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs." Pub. L. No. 89-97, § 102, 79 Stat. 322-323 (§ 1861(v)(1)).

[11] The denomination of the clause—"(B)" in the original Act—was changed to "(ii)" in 1972, when Section 1861(v) was amended and reorganized into subsections (A)-(E). See Pub. L. No. 92-603, §§ 227(c), 249(b), 86 Stat. 1405, 1426.

The original regulations also implemented the accounting and payment provisions of the Act. The introductory regulation noted as a basic principle that reimbursement was to be furnished on the basis of actual and current (rather than historical or fixed) costs. 20 C.F.R. 405.402(a) (1967). Thus, "the methods of reimbursement should result in current payments," so as not to force institutions to advance funds well before receiving payment, and "there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively." 20 C.F.R. 405.402(b)(1)-(2). Section 405.405(c) of the regulations then described generally the integrated process adopted to achieve these dual ends:

> Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. * * * The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

The subsequent, more detailed sections of the regulations reiterated and elaborated upon this basic scheme. Section 405.451(b)(1), defining "reasonable cost," noted:

> These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year * * * and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

Finally, Section 405.454, which contained the most detailed description of the mechanics of the payment system, provided in subsections (c) through (e) for interim payments based on estimates of costs incurred, with adjustments in light of actual experience. Subsection (f) then provided for initial and final retroactive adjustments to be made at the end of the reporting period (the first before the audit and the latter after), in order to balance the total of the interim payments made during the period with the aggregate reimbursement ultimately determined to be due to the provider under the regulations governing cost allowance and apportionment.

As this Court has noted, the language of Sections 405.451 and 450.454 makes clear that they were intended specifically to implement clause (ii). *Georgetown University Hospital*, 488 U.S. at 211-212 n.2. Together with the other provisions of the regulations outlined above, they demonstrate that clause (ii) was understood to impose an important but limited requirement on the Medicare program's system of reimbursement accounting: that whatever *interim* cost estimates might be used to satisfy the statutory command to pay providers no less often than monthly, the regulations must ensure that each provider ultimately received no more or less than the amount that would compensate it fully for the allowable costs—determined as provided elsewhere in the regulations—it actually incurred in providing care to covered patients during a given period. No other role (including that posited by petitioners) was assigned to clause (ii) by the Secretary. As the contemporaneous interpretation of a complex regulatory statute by the agency charged with its implementation, this construction of the Act is, of course, entitled to great weight. *E.I. DuPont de Nemours & Co.* v. *Collins*, 432 U.S. 46, 55 (1977) (quoting *FTC* v. *Mandel Bros.*, 359 U.S. 385, 391 (1959)); see also *Davis* v. *United States*, 495 U.S. 472, 484 (1990); *Red Lion*

Broadcasting Co. v. *FCC*, 395 U.S. 367, 381 (1969); *Udall* v. *Tallman*, 380 U.S. 1, 16 (1965).

It also is significant that this interpretation was brought to Congress's attention at the outset of the program. In May, 1966, the Senate Finance Committee—the committee directly responsible for the legislation passed by the same Congress only a few months before—held working hearings to consider in detail several issues raised by the Secretary's draft reimbursement regulations. See generally *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. (1966).[12] Congressional and Executive Branch participants during these hearings referred repeatedly to the retroactive adjustment provision of the statute as a year-end, book-balancing mechanism. See *id.* at 66 (HEW General Counsel Willcox) ("The law specifically provides for retroactive adjustment at the end of an accounting period" to correct over-reimbursements); *id.* at 67 (Social Security Commissioner Ball); *id.* at 96 (Chief Counsel, Senate Finance Committee) (the legislation "probably * * * permit[s] an estimate" of costs, "provided that adjustments, retroactive adjustments, which are authorized by the statute, would recapture any excess payments" and make up any underpayments); *id.* at 109 (Senator Anderson) ("There is a provision in the bill, I believe, that lets you go back at the end of a year and refigure your bills."). Given the

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[12] These issues included whether depreciation on assets paid for with public funds should be allowed as a cost, whether the statute authorized the Secretary to pay more than the actual costs of care, the propriety of including return on investment as a cost for proprietary but not for non-profit facilities, and the legality and desirability of paying participating providers one month's estimated reimbursement in advance. See *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 3 (1966).

specific mention of "retroactive" adjustments, we think it clear that these statements refer to clause (ii), and support the Secretary's construction of its function.[13]

Finally, in his first annual report to Congress on the operation of the Medicare system, the Secretary summarized the reimbursement procedure in similar terms, again invoking clause (ii)'s language of "retroactive adjustment":

> Under procedures in effect from the start of program operations, interim payments approximating a provider's actual costs are made, at least monthly, and in most cases, weekly, by intermediaries as bills for covered services are submitted. Intermediaries make appropriate adjustments in the interim rate of payment and lump-sum payments to bring past payments in line with costs during the reporting period. *A retroactive adjustment based on the actual costs is made at the end of the provider's reporting period.*

1st Annual Report On Medicare, H.R. Doc. No. 331, 90th Cong., 2d Sess. 41 (1968) (emphasis added); see also *id.* at 9.

Thus, from the beginning of the Medicare program, the function of clause (ii) was to authorize an annual reconciliation between the aggregate amount of the interim payments made to providers during the year and the aggregate amount actually found to be owing under the applicable methods prescribed for determining reasonable costs. There was no suggestion of the far different and more expansive role petitioners urge, under which clause (ii) would furnish independent authority for a provider (or the Secretary) to alter or evade the substantive determination of reasonable costs under governing regulations.

c. Petitioners do not dispute that the regulations discussed above provided for no more than year-end book balancing; they claim instead that the entire authority for such regulations is properly found in 42 U.S.C. 1395g, rather than in clause (ii) of 42 U.S.C. 1395x(v)(1)(A). See Pet. Br. 19-21, 23. Petitioners are wrong. To begin with, their argument ignores the fact that, whatever petitioners may now assert, those charged with the initial implementation of the Medicare program considered clause (ii) to be the statutory basis for the retroactive annual adjustment mechanism they so thoroughly embedded in the regulatory scheme. See *Georgetown Uni-*

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[13] During the Finance Committee hearings the following colloquy occurred (at 119-120) between Senator Anderson and Social Security Commissioner Ball, concerning the operation of the provider reimbursement process (the specific question being the propriety of a proposed 2% allowance for costs not specifically identified):

> Senator Anderson: What does the law require?
>
> Mr. Ball: That we pay cost.
>
> Senator Anderson: If you find out you haven't paid cost—you have to pay it then. Why don't you find out about it?
>
> Mr. Ball: I don't think that the retroactive provision contemplates going back over the year and changing the principles. I think what is contemplated is that you pay first on the basis of * * * estimates * * *. [Y]ou make an estimate at the beginning of the year on the basis of these principles. Then at the end of the year you settle up, on the basis of the principles put out. It would hardly seem reasonable at the end of the year, after hospitals had entered into an agreement with you on the basis of certain principles, to shift all the principles for retroactive settlement in terms of how you compute a cost. I don't think that was contemplated at all.
>
> Senator Anderson: Well, why cannot a hospital find out what its costs are at the end of the first year?
>
> Mr. Ball: Well, the question of what are the costs is a matter of what principes are agreed upon as the basis for the cost determination.

Both Congress and the Executive understood from the outset of the Medicare program that the function of clause (ii) was to authorize a "settl[ing] up" at "the end of the year," based on the appropriate "principles" of reimbursement, whatever those "principles"—defined elsewhere in the law and regulations—might be.

versity Hospital, 488 U.S. at 211 n.2.[14] Petitioners cite no evidence that anyone at the time thought differently. Their argument (Pet. Br. 20-21 n.18) that such regulations should now be thought to rest exclusively on 42 U.S.C. 1395g comes far too late in the history of the program.

In any event, there is no merit to petitioner's contention that 42 U.S.C. 1395g fully addressed the subject of annual book-balancing, so that the Secretary's interpretation of clause (ii) would render it redundant. Then as now, 42 U.S.C. 1395g provided for periodic interim payments "prior to audit or settlement," including "necessary adjustments on account of previously made overpayments or underpayments." 79 Stat. 297; 42 U.S.C. 1395g(a). That language is fully reflected in both the original and the current reasonable cost regulations, which repeatedly provide for adjustments to the amount of the numerous interim payments made *during the course of the fiscal year*, based on estimated costs. See 20 C.F.R. 405.405(d); 405.454(c)(4), (d)(2), (e), (f)(1) (1967) (now codified at 42 C.F.R. 413.64(c)(4), (d)(2), (e), (f)(1)).[15] It contrasts with the "retroactive corrective adjustments"

[14] Indeed, the statutory authority cited by the Secretary for the initial cost reimbursement regulations as a whole included only Social Security Act Section 1814(b) (the general requirement for reasonable cost reimbursement) *and Section 1861(v)* (the reasonable cost provision that includes clause (ii))—in addition to the general rulemaking provisions in Sections 1102 and 1871 of the Act, 42 U.S.C. 1302 and 1395hh. See 31 Fed. Reg. 14,808 (1966). There was no mention of Section 1815 of the Act, 42 U.S.C. 1395g.

[15] For example, Section 405.454(e) of the original regulations, now 42 C.F.R. 413.64(e), provided that the "interim rate of payment may be adjusted by the intermediary during an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate."

language taken from clause (ii), which also occurs repeatedly in the regulations, and which refers to a comparison of the aggregate reimbursement produced by the interim payments and the aggregate post-audit reimbursement ultimately determined to be due, producing one final *year-end* adjustment. See, *e.g.*, 20 C.F.R. 405.451(b)(1), 405.454(f) (1967) (now codified at 42 C.F.R. 413.9(b)(1)). The different statutory provisions thus speak to different phases of the reimbursement process; neither is "mere surplusage." See Pet. Br. 23.[16]

[16] It is possible that if clause (ii) had not been enacted, the authority for some similar year-end mechanism might have been inferred under the Act as a whole, including 42 U.S.C. 1395g. But the fact that Congress made clear what might have been inferred hardly renders the clarification "surplusage."

Furthermore, the interim and annual adjustment provisions serve different legislative purposes, which explains their different statutory placement. As the initial regulations explained, the interim payments prescribed by 42 U.S.C. 1395g are intended to protect participating providers' liquidity. See 20 C.F.R. 405.402(b)(1) (1967). In order to serve that goal without unduly burdening the fisc or subsidizing providers' non-program costs, it made sense to provide that whatever estimates were used for interim payments should be adjusted periodically to ensure that they were as accurate as possible. See 20 C.F.R. 405.454(b). It was also a guiding principle of the Act and regulations, however, that payment would be made "on the basis of current costs * * * rather than costs of a past period or a fixed negotiated rate." 20 C.F.R. 405.402(a). The year-end "retroactive adjustment" was thought of primarily as a means to ensure that reimbursed costs ultimately would exactly equal the provider's actual costs (insofar as they were "reasonable"). See *id.* § 405.402(b)(2). See also S. Rep. No. 404, *supra*, at 37 ("[i]n paying reasonable costs it should be the policy of the insurance program to so reimburse a hospital or other provider that an accounting may be made at the end of each cost period for costs actually incurred"). Because Congress thought of the year-end retroactive "corrective" adjustments to aggregate reimbursement primarily in terms of maintaining the integrity of the reasonable cost reimbursement principle, it is not surprising that the clause specifically requiring such adjustments was included in the statutory provision that dealt most specifically with that principle (42 U.S.C. 1395x(v)(1)(A)), not in the section dealing with interim payments of estimated and unaudited costs (42 U.S.C. 1395g).

2. *The 1972 Cost Limit Amendments*

The early history of clause (ii), just discussed, demonstrates that while that clause serves an important function in implementing the general principle of reimbursing providers for their actual (as opposed to estimated) reasonable costs, it does not speak to the question of what costs are to be recognized as "reasonable." That question must be answered instead by reference to principles and methods set forth elsewhere, including in the remainder of 42 U.S.C. 1395x(v)(1)(A) and the regulations thereunder. Congress itself has from time to time altered those principles, or directed changes in the applicable methods. It did so for the first time in 1972, when it adopted the cost limit principle at issue in this case. Those amendments further undermine petitioners' reliance on clause (ii) to avoid the cost limits.

a. The original Medicare Act had contemplated—and the initial regulations had confirmed—that providers' reimbursable costs might vary widely, and that, within broad limits, each provider should be compensated for its "actual costs of providing quality care." 20 C.F.R. 405.451(c) (1967). See, *e.g.*, S. Rep. No. 404, *supra*, at 35-36. By 1971, however, Congress had become concerned that "reasonable cost" reimbursement under the 1965 Act essentially permitted providers to recover whatever costs they might incur, even when those costs resulted from inefficiency or inappropriate expenditures. See H.R. Rep. No. 231, *supra*, at 82-85; S. Rep. No. 1230, *supra*, at 188-189.[17] As the Committee reports concluded,

[17] Although under the 1965 Act the Secretary had "authority to disallow incurred costs that are not reasonable," Congress recognized that this system presented problems for both the Secretary and providers. See H.R. Rep. No. 231, *supra*, at 83. Because the Secretary could disallow costs only on a case-by-case basis, it was often difficult to establish that a particular provider's costs were out of line. On the other hand, disallowance of costs already incurred by a provider "create[d] financial uncertainty for the provider" since it "ha[d] no way of knowing until sometime after it incur[red] expenses" whether they would be comparable to those of other providers in the same period and, therefore, "allowable" under the Secretary's regulations. *Ibid.*

> Health care institutions, like other entities in our economy, should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately, a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

H.R. Rep. No. 231, *supra*, at 83; S. Rep. No. 1230, *supra*, at 187.[18]

In 1972, therefore, Congress toughened the governing principles of cost reimbursement. The new law added to the first sentence of 42 U.S.C. 1395x(v)(1)(A) a new statutory definition of "reasonable cost": "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." Pub. L. No. 92-603, § 223(a), 86 Stat. 1393. It then authorized the Secretary to promulgate regulations establishing "limits on the * * * incurred

[18] Congress's concern with controlling improper costs disposes of petitioners' argument (Pet. Br. 16) that the "inevitable consequence" of the Secretary's position will be to shift part of the cost of treating Medicare patients to non-Medicare patients, in violation of clause (i) of 42 U.S.C. 1395x(v)(1)(A). Because a provider could always be expected to claim that it would be "forced" to shift costs in excess of the Secretary's limits to non-Medicare patients, petitioners' argument would vitiate the cost limit concept. But Congress clearly did not intend the Medicare program to be held to account for a provider's decision to foist onto its other patients costs that Congress and the Secretary had concluded were not otherwise reimbursable.

costs * * * to be recognized as reasonable" for Medicare purposes, "based on estimates of the costs necessary in the efficient delivery of needed health services" to covered individuals. *Ibid.* The new limits were expected to be imposed prospectively, so that providers "would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable." S. Rep. No. 92-1230, *supra*, at 188.

As explained above, the Secretary first published cost limit regulations in 1974, and has issued a series of implementing announcements annually since that time.[19] See pages 4-5, *supra*. The regulations establish the basic principle that costs in excess of the applicable limits are not reimbursable under Medicare. See 20 C.F.R. 405.460(a) (1975); 42 C.F.R. 413.30(a). The regulations also provide, however, for limited exceptions to and exemptions from the limits in particular situations in which reasonable costs might be expected or shown to exceed the limits. See 20 C.F.R. 405.460(f) (1975), redesignated as 42 C.F.R. 413.30(e) and (f). Since 1974, the Secretary has acted to expand these regulatory exceptions in the light of program experience. See, *e.g.*, 44 Fed. Reg. 31,802 (1979).

Petitioners concede (Pet. Br. 22 n.19) that they do not qualify for any regulatory exception to or exemption from the applicable cost limits. They contend instead that clause (ii) confers on them a substantive right to individual, *ad hoc* adjudications of their claims that certain of their costs were "reasonable," and hence reimbursable without regard to any other standard. That contention is untenable.

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[19] The cost limits promulgated by the Secretary have never covered all costs reimbursable under the general "reasonable cost" standard. The first set of limits, for example, applied only to hospital inpatient general routine service costs. 39 Fed. Reg. 20,168-20,169 (1974). Thus, in periods when costs limits applied, most providers would be expected to have some costs which were subject to limitation and other costs subject only to the original "substantially out of line" standard of 20 C.F.R. 405.451(c)(2) (1967) (now codified at 42 C.F.R. 413.9(c)(2)).

Petitioners argue (Pet. Br. 17) that the 1972 amendments "left clause (ii) intact." We agree. There is nothing to suggest that the 1972 Congress intended to change the annual book-balancing system established by the regulations under clause (ii). Indeed, the fact that Congress declined to alter the text of clause (ii)—even though it substantially revised 42 U.S.C. 1395x(v)(1)(A) in other respects—strongly supports the soundness of the Secretary's implementation of clause (ii) through the book-balancing regulations that were in effect from 1967 onwards.

It does not follow, however, as petitioners contend (Pet. Br. 16-17), that the 1972 amendments did not change the principles of reasonable cost reimbursement. On the contrary, the natural reading of the amendments (and their legislative history) is that they did exactly what the term "cost limits" would imply: they authorized the "establishment of limits" on the costs that would be "recognized as reasonable" for Medicare purposes. 86 Stat. 1393. It is that straightforward change that petitioners seek to avoid through their misinterpretation of clause (ii).

b. Petitioners stress selected phrases from the legislative history of the 1972 amendments, including that the limits would be imposed on a "presumptive" basis and that providers would have "the right to obtain reconsideration of their classification for purposes of the cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception." S. Rep. No. 1230, *supra*, at 188-189. Those comments suggest noting more than an intention that the Secretary should make some provision for exemptions or exceptions from the cost limits in appro-

priate cases.[20] This the Secretary has done. See 42 C.F.R. 413.30(c)-(f) ("Provider requests regarding applicability of cost limits"—"Reclassification," "Exemptions" and "Exceptions").

In fact, petitioners are merely trying to press clause (ii) into service to fight again a battle that they have already lost. In the courts below, petitioners directly challenged the reasonableness of the cost limits applicable to them, and sought an order declaring those limits invalid. Pet. App. 14a-15a; J.A. 13-15, 18-19. The court of appeals rejected petitioners' arguments, concluding that "[t]here is nothing arbitrary or capricious about the cost limit methodology used by the Secretary." Pet. App. 14a-15a. That ruling was clearly correct,[21] and in any event petitioners have not challenged it in this Court. Instead, they now seek to attack the cost limits in a different way, by claiming that although they are

[20] The Committee reports themselves suggested one such exemption, for sole community hospitals. See S. Rep. No. 1230, *supra*, at 188; 42 C.F.R. 413.30(e)(1).

[21] The courts have recognized that Medicare regulation "cannot be accomplished on a hospital-by-hospital basis," and that the Secretary "must make generalizations in achieving [the] overall regulatory goals" of the Medicare program. *City of Austin* v. *Heckler*, 753 F.2d 1316, 1317-1318 (5th Cir. 1985). Accord, *Fairfax Hosp. Ass'n, Inc.* v. *Califano*, 585 F.2d 602, 606 (4th Cir. 1978). The fact that the Secretary's cost limit regulations provide relief for only "some" providers, and not for petitioners (see Pet. Br. 22), hardly impugns the rationality of the Medicare reimbursement system. The Secretary was certainly justified in not accounting for part-time employees in his wage index, given the paucity of accurate information available at the time. Indeed, when Congress directed the Secretary to develop the necessary data, it explicitly made the revised wage index applicable only to costs for patients discharged on or after May 1, 1986. Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9103(a), 100 Stat. 156 (1986). Similarly, the Secretary's use of location in or outside an SMSA to classify hospitals for reimbursement purposes may be imperfect, but is certainly rational.

valid in general, clause (ii) allows them to be circumvented in particular. But even if clause (ii) might have been given a more expansive role when cost limits did not apply, the Secretary surely could determine after 1972 that it would not be "suitable" to make "retroactive corrective adjustments" under that clause where the only rationale for doing so would be to permit a provider to avoid the cost limits that were validly promulgated pursuant to the 1972 amendments to 42 U.S.C. 1395x(v)(1)(A).[22]

C. Petitioners' Reliance On Clause (ii) In This Case Is Foreclosed By This Court's Decision In *Bowen* v. *Georgetown University Hospital*

The result that petitioners seek in this case is also inconsistent with this Court's construction of clause (ii) and the cost limits in *Bowen* v. *Georgetown University Hospital*, *supra*. In *Georgetown* the Secretary, relying on expansive readings of clause (ii) by some lower courts in cases brought by providers, see pp. 38-39, *infra*, argued that the clause provided statutory authority for the promulgation in 1984 of regulations applicable retroactively as of July 1, 1981. See 488 U.S. at 209. The Court, however, rejected this interpretation. Indeed, the Court cited the book-balancing regulations discussed above, 20 C.F.R. 405.451(b)(1), 405.454(a) and (f) (1967), as indicative of the Secretary's prior—and, implicitly, correct—implementation of clause (ii). 488 U.S. at 211-212 & n.2; see also *id.* at 212-213.

The Court commented in *Georgetown* that the statutory language "suggests that clause (ii), rather than permitting modifications to the cost-method rules in their

[22] It is of course axiomatic that revised statutory provisions prevail over prior law as "the latest declaration of the legislative will." N. Singer, *Sutherland Statutory Construction* §§ 22.34 (at 293), 51.02 (at 121) (1985). See also, *e.g.*, *Clark* v. *Uebersee Finanz-Korporation*, 332 U.S. 480, 489 (1947).

general formulation, is intended to authorize case-by-case inquiry into the accuracy of reimbursement determinations for individual providers." 488 U.S. at 210. Moreover, the Court observed that the cost limit rules are one of the "methods of determining costs" referred to in the language of clause (ii), and that "nothing in clause (ii) suggests that it permits changes in the *methods* used to compute costs; rather, it expressly contemplates corrective adjustments to the *aggregate amounts* of reimbursement produced pursuant to those methods." *Id.* at 211 (emphasis in original). Finally, the Court expressed its view that "clause (ii) directs the Secretary to establish a procedure for making case-by-case adjustments to reimbursement payments where the regulations prescribing computation methods do not reach the correct result in individual cases." *Id.* at 209.

The Court's observations in *Georgetown* are fully consistent with the "narrow view," 488 U.S. at 212-213, which the Secretary originally espoused and to which he has returned in light of this Court's decision in that case. Clause (ii) speaks of corrective adjustments to the aggregate reimbursement produced by the "methods of determining costs" prescribed under 42 U.S.C. 1395x (v)(1)(A)—*i.e.*, standards of allowability, methods of apportionment, and cost limits. These methods are first applied in the process of estimating the appropriate interim reimbursement rates required by 42 U.S.C. 1395g and the regulations. See, *e.g.*, 42 C.F.R. 413.60, 413.64. Cf. *id.* § 413.5(b)(1) (emphasis added) (stating that "the *methods of reimbursement* should result in current payment"—under the interim payment system—to preserve provider liquidity). The interim application of the cost determination methods, and the payments calculated thereunder, will always be based on estimates. Thus, in practice, the "aggregate reimbursement produced" by applying the prescribed "computation methods"—*i.e.*, the total of all of the interim payments made during the

year—will always require a "suitable retroactive corrective adjustment" of some sort. Clause (ii) thus speaks only to correcting the results of the necessary inaccuracies involved in the interim cost estimation process. It does not authorize a *post hoc* revision of the substantive methods applied both in generating those estimates and in reconciling the provider's aggregate provisional reimbursement with the amount finally determined, after audit, to be due.

Petitioners nevertheless rely on *Georgetown*. Pet. Br. 14-15, 20-21 n.18, 27-28. They argue that the Court there drew a distinction between retroactive rulemaking and "case-by-case adjustments," invalidating only the former.[23] Petitioners argue that they seek only a "case-by-case" retroactive change in the Secretary's methods where those methods "produce inadequate reimbursement of [their] reasonable costs." Pet. Br. 15; see also *id.* at 22, 27-28.[24] But petitioners' approach would permit providers—or the Secretary—to seek retroactive modifications having the same practical effect as the retroactive rulemaking barred by this Court in *Georgetown*.

The district judge in *Mt. Diablo Hospital*, *supra*, recognized this consequence, noting that clause (ii) is a "two way street" in that it "applies to adjustments where the

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[23] We agree that clause (ii) requires "case-by-case adjustments." But they must be "adjustments" to the provider's "aggregate reimbursement" within the framework of the Secretary's reimbursement regulations—not, as petitioners seek here, *ad hoc* adjustments designed to circumvent the Secretary's lawful regulations.

[24] Petitioners ask this Court to remand their case to the Provider Reimbursement Review Board for "the opportunity to demonstrate that their costs in excess of the cost limits are reasonable." Pet. Br. 29. In the court of appeals, they argued for an across-the-board adjustment to their wage index, regardless of their actual costs or percentage of part-time employees. Pet. C.A. Rep. Br. 16 n.8; Gov't C.A. Reply Br. 6. The court of appeals recognized that this amounted to a request for a "retroactive rule chang[e]," and rejected the argument. Pet. App. 13a.

aggregate reimbursement is shown to be '. . . either inadequate or excessive.'" *Mt. Diablo Hospital Medical Center* v. *Sullivan*, No. C-89-2714-DLJ (N.D. Cal. May 24, 1990), slip op. 13, rev'd, 963 F.2d 1175 (9th Cir. 1992), petition for cert. pending, No. 92-720. As the judge explained,

> Under [the provider's] interpretation of clause (ii), the Secretary in the *Georgetown Univ. Hospital* scenario could have determined the claimed expenses to be unreasonable and retroactively adjusted such "excessive" payouts on a hospital-by-hospital basis, even after the Supreme Court held that the Secretary was without rule-making authority under clause (ii). Such a result could not have been within the contemplation of the Supreme Court. Case-by-case retroactive adjudication ultimately has the same practical effect as across-the-board retroactive rule-making.

Slip op. 13-14. The court of appeals in this case agreed, stating that petitioners' request for a court order requiring the Secretary "to retroactively adjust cost limits for the number of part-time workers * * * amount[s] to a retroactive change in the *methods* that, after *Georgetown*, is invalid." Pet. App. 13a. See also *Hennepin County* v. *Sullivan*, 883 F.2d 85, 86-87, 92-93 (D.C. Cir. 1989), cert. denied, 493 U.S. 1043 (1990) (clause (ii) "is not a vehicle through which Medicare providers may get a 'second bite at the applie' on claims for exceptions to limitations on reimbursable costs"); *Sierra Medical Center* v. *Sullivan*, 902 F.2d 388, 393 (5th Cir. 1990).

Neither *Georgetown's* holding nor its discussion of clause (ii) can be reconciled with petitioners' position in this case. However they may characterize their argument, petitioners at bottom are attempting to use clause (ii) to avoid the application to them of otherwise valid cost limits. Yet *Georgetown* specifically states that the clause does not permit changes in the methods, including cost limits, used to compute reimbursable cost. 488 U.S. at 211.

Moreover, although the Court in *Georgetown* stressed the individual, case-by-case nature of whatever adjustment is required by clause (ii)—consistent with the provider-specific details of a yearly reconciliation between estimated payments and actual costs—the logic of petitioner's position would allow *any* similarly situated provider to demand equal treatment, thus accomplishing in effect a wholesale revision of the cost limit rules. See Pet. Br. 22, 27-28.[25]

D. The Secretary's Interpretation Of Clause (ii), Which Is Consistent Both With *Georgetown* And With The Original Construction Of The Statute, Is Entitled To Deference From This Court

Petitioners argue (Br. 23-25) that any claim of deference to the Secretary's construction of the Medicare Act is undermined by variations in the government's positions over the years. While the Secretary's position on the

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[25] Petitioners' reliance (Br. 25-27) on *Bethesda Hospital Ass'n* v. *Bowen*, 485 U.S. 399 (1988) as a basis for disregarding the Secretary's cost limit regulations is similarly unavailing. That case involved a *procedural* question of exhaustion of administrative remedies—namely, whether a provider is required to raise a reimbursement issue before its fiscal intermediary in order to preserve that claim for review by the PRRB. Relying on the text of a statutory provision not at issue here, 42 U.S.C. 1395*oo*, the Court held that the Act imposes no such exhaustion requirement. 485 U.S. at 403-405. Nothing in the Court's decision suggests that the PRRB may ignore *substantive* limitations in the Secretary's regulations, including those imposing cost limits. Indeed, the Court observed that the PRRB cannot "declare regulations invalid" (485 U.S. at 406 (citing 42 U.S.C. 1395*oo*(f)(1)) and that the providers acknowledged that the PRRB lacked "authority" to disregard the Secretary's regulations and to give them "the relief they sought." Furthermore, the instances cited by petitioners where "the [PRRB] has actually served as the mechanism for clause (ii) adjustments" in disregard of the Secretary's regulations have all occurred in situations where the courts have specifically ordered such a result. See cases cited at Pet. Br. 27.

meaning of clause (ii) did in fact vary at times between the inception of the program and 1988, positions differing from that reflected in the original Medicare regulations stemmed largely from the disarray that prevailed for some time among the lower courts on this issue. Furthermore, since this Court's construction of clause (ii) in *Georgetown*, the Secretary has returned to the "book-balancing" interpretation reflected both in that decision and in the initial Medicare regulations.

The federal courts, like the Secretary, initially adopted the "book-balancing" interpretation. See, *e.g.*, *Mt. Sinai Hospital of Greater Miami, Inc.* v. *Weinberger*, 376 F. Supp. 1099, 1127-1129 (S.D. Fla. 1974) (analyzing the relationship between clause (ii) and 42 U.S.C. 1395g(a)), aff'd, 517 F.2d 329, 335 (5th Cir. 1975). In the mid-1970's, however, the Second Circuit and the United States Court of Claims rejected the Secretary's arguments that his "book-balancing" regulations fully implemented clause (ii), finding instead that the clause required the Secretary to retroactively change his reimbursement methods "wherever a cost method produce[d] an inaccurate reimbursement." *Whitecliff, Inc.* v. *United States*, 536 F.2d 347, 351-352 & n.11 (Ct. Cl. 1976) (retroactive application of subsequently collected data); *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663, 669-671 (2d Cir. 1973) (retroactive application of subsequently issued Medicare ruling to earlier cost years).

Whatever type of adjustments clause (ii) authorizes apply to "excessive" as well as to "inadequate" prior payments. In light of *Whitecliff* and *Kingsbrook*, therefore, the Secretary in the late 1970's argued for a more substantive role for clause (ii), principally to recoup through "retroactive corrective adjustments" accelerated depreciation that had been claimed in earlier years by providers that subsequently left the Medicare program.

Fairfax Nursing Center v. *Califano*, 590 F.2d 1297 (4th Cir. 1979); *Springdale Convalescent Center* v. *Mathews*, 545 F.2d 943, 954 (5th Cir. 1977); *Hazelwood Chronic & Convalescent Hospital, Inc.* v. *Weinberger*, 543 F.2d 703 (9th Cir. 1976), vacated on other grounds, 430 U.S. 952 (1977); *Humana of South Carolina* v. *Califano*, 590 F.2d 1070, 1079 n.66 (D.C. Cir. 1978).[28] But see *Daughters of Miriam Center for the Aged* v. *Mathews*, 590 F.2d 1250 (3d Cir. 1978) (rejecting application of accelerated depreciation regulations to pre-issuance conduct). Further, in the early 1980's, when the cost limit issues present in this case began to appear in litigation, several lower courts initially adopted a similar reading of clause (ii). *Medical Center Hosp.* v. *Bowen*, 839 F.2d 1504 (11th Cir 1988); *St. Paul-Ramsey Medical Center* v. *Bowen*, 816 F.2d 417 (8th Cir. 1987); *Regents of the Univ. of California* v. *Heckler*, 771 F.2d 1182 (9th Cir. 1985).

As is obvious from the discussion above, however, any reading of clause (ii) that would permit retroactive

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[28] *Mercy Community Hosp.* v. *Blue Cross Association/Blue Cross of Florida, Inc.*, [1983-1 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 32,316, at 9542 (Nov. 4, 1982), cited by petitioners, Pet. Br. 24, is a similar case.

Humana of Illinois, Inc. v. *Heckler*, No. 84-1727 (7th Cir. Apr. 18, 1985), consolidated with *St. James Hospital* v. *Heckler*, 760 F.2d 1460, 1473 n.9 (7th Cir.), cert. denied, 474 U.S. 902 (1985), is also similar. The brief filed by the Secretary in that case and cited by petitioners here (Pet. Br. 13-14 n.13, 24) argued that the regulations on reopening of determinations and decisions, 42 C.F.R. 405.1885(a) (1984), were authorized by clause (ii). Particularly in light of the intervening decision in *Georgetown*, the Secretary now believes that the reopening regulations are properly premised not on clause (ii), but on the Secretary's general rulemaking authority. See 42 U.S.C. 1395hh. Lower courts have accepted that position without comment. See *Memorial Hospital* v. *Sullivan*, 779 F. Supp. 1406, 1409 (D.D.C. 1991); *Albert Einstein Medical Center* v. *Sullivan*, Civil No. 91-6119 (E.D. Pa. Nov. 24, 1992), slip op. 12.

changes in the Secretary's methods of reimbursement whenever they resulted in "inadequate" or "excessive" payments was rejected by this Court in *Georgetown*. Indeed, although the issue was not directly presented, *Georgetown* appeared to adopt the Secretary's original "book-balancing" construction of clause (ii). See 488 U.S. at 210-212 & n.2, 213.

Since *Georgetown*, the Secretary has returned to this original construction. His position here takes into account this Court's authoritative construction of clause (ii), see *Lechmere, Inc.* v. *NLRB*, 112 S. Ct. 841, 847-848 (1992), as well as his interpretation of other relevant statutory provisions and his accumulated experience in administering the Medicare program. See Pet. App. 10a-14a; *Hennepin County* v. *Sullivan*, 883 F.2d at 86-87, 92-93; *Sierra Medical Center* v. *Sullivan*, 902 F.2d at 393.[27] The

[27] *Sutter Community Hospitals* v. *Heckler*, No. S-82-204 (RAR) (E.D. Cal. Feb. 16, 1984), aff'd, 765 F.2d 150 (9th Cir. 1985) (Table), cited by petitioners, Pet. Br. 24-25, is not to the contrary. In that case, the Secretary was under a final, non-appealable judgment, entered prior to *Georgetown*, requiring "reimbursement of any costs the providers could establish were reasonable, even if total routine costs exceeded the limitations." *Eskaton American River Hosp.* v. *Aetna Life Ins. Co.*, [1990 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 38,279, at 21,549 (Nov. 27, 1989), citing *Sutter Community Hospitals* v. *Heckler*, *supra*. The fact that the Secretary, after *Georgetown*, chose not to attempt to apply *Georgetown*'s holding in such a pending case surely does not indicate any relevant inconsistency. See *United States* v. *Mendoza*, 464 U.S. 154, 160-161 (1984). Indeed, petitioners appear to suggest that in order to avoid any embarrassing "inconsistency" the Secretary should have taken a position that would have led to litigation in a circuit that had already ruled against the government's position on the issue. See *Regents* v. *Heckler*, *supra*.

The HCFA Ruling cited by petitioners (Br. 25 n.21) is similar. HCFA Ruling No. 89-2, [1990 Transfer Binder] *Medicare and Medicaid Guide* (CCH) ¶ 38,236, at 21,297 (Oct. 31, 1989). It dealt with the reimbursement of costs incurred by health maintenance organizations and competitive medical plans, which at the time were subject to absolute cost limits similar to those at issue here, but

fact that the Secretary once took a somewhat broader view of clause (ii) does not excuse the courts from according deference to the Secretary's current interpretation, especially since that interpretation is identical to the Secretary's interpretation of clause (ii) immediately after its enactment, and has been incorporated in book-balancing regulations that have remained in effect ever since. That interpretation accords clause (ii) its proper and accustomed role in the complex system of Medicare reimbursement, and preserves the integrity of the cost limits that Congress authorized to promote efficiency and fairness among providers and to facilitate administration of the program through rules of general applicability. By contrast, petitioners' expansive view of clause (ii) would undermine the cost limits, require *ad hoc* decisionmaking concerning the amount of reimbursement owed to thousands of providers annually (see note 3, *supra*), and

with no provision for exceptions such as those available under 42 C.F.R. 413.30(f). The ruling announced (1) that in light of *Medical Center Hospital* v. *Bowen*, *supra*, and *Regents* v. *Heckler*, *supra*, the relevant regulations would be revised to provide appropriate exceptions, and (2) that although, in light of *Georgetown*'s disapproval of retroactive cost-limit regulations, the new regulations would not be retroactive, as a matter of enforcement policy the absolute limits would not be applied pending revision of the regulations. The ruling did not consider the continuing validity of *Medical Center Hospital* and *Regents* in light of *Georgetown*'s construction of clause (ii). Moreover, the ruling relates to clause (ii) solely because of the similar language adopted by Congress in 1972 in 42 U.S.C. 1395mm(h)(3), governing "reasonable cost" reimbursement to health maintenance organizations. If anything, that Section's language (providing for "suitable retroactive corrective adjustments *at the end of each contract year*" (emphasis added)) and structure (as an alternative to an incentive payment system premised on year-end accounting) support the Secretary's construction of the same phrase as used in clause (ii). In any event, the ruling is consistent with the proposition that any obligation to provide appropriate adjustments to cost limits of general applicability is satisfied by the exemptions and exceptions provided by the cost-limit regulations. See pages 31-32, *supra*.

thereby undermine the statutory goals of efficiency, fairness, and ease of administration.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

KENNETH W. STARR
Solicitor General

STUART M. GERSON
Assistant Attorney General

EDWIN S. KNEEDLER
Assistant to the Solicitor General

EDWARD C. DUMONT
Assistant to the Solicitor General

SUSAN K. ZAGAME
Acting General Counsel

ANTHONY J. STEINMEYER
JOHN P. SCHNITKER
Attorneys

DARREL J. GRINSTEAD
Associate General Counsel

HENRY R. GOLDBERG
Deputy Associate General Counsel

GERARD KEATING
Attorney
Department of Health & Human Services

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